(Revised as of April 21, 2004)

# TESTIMONY OF MARTHA B. KNISLEY
# DIRECTOR
# DEPARTMENT OF MENTAL HEALTH

## ON THE
## FY 2005 BUDGET REQUEST

## BEFORE THE COMMITTEE ON HUMAN SERVICES

## COUNCILMEMBER SANDY ALLEN, CHAIR

## THURSDAY, APRIL 22, 2004

## COUNCIL CHAMBER
## JOHN A. WILSON BUILDING
## 1350 PENNSYLVANIA AVENUE, N.W.
## WASHINGTON, D.C. 20004

**TESTIMONY OF MARTHA B. KNISLEY**
**DIRECTOR, DEPARTMENT OF MENTAL HEALTH**
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**BEFORE THE COMMITTEE ON HUMAN SERVICES**
**COUNCILMEMBER SANDY ALLEN, CHAIR**
**THURSDAY, APRIL 22, 2004/4 PM-9 PM**

- Good afternoon, Chairwoman Allen, members of the Committee on Human Services, members of the Council and staff.

- I am Martha B. Knisley, Director of the Department of Mental Health. With me today are Dave Norman, Deputy General Counsel; Marie-Claire Brown, Director of Contracts and Procurement; and Deloras Shepherd, Associate Chief Financial Officer for the Human Services cluster.

- Thank you for this opportunity to discuss the Mayor's FY 2005 proposed budget for the Department of Mental Health. I want to express my gratitude to you, Chairwoman Allen, members of the committee and the Council for your support, guidance and forbearance as we travel this bumpy road to a new public mental health system for the District and our citizens.

- While the Court-ordered Plan established how this system will function, what services will be provided and how, who is qualified to provide those services, and even the budget, it leaves out the steps along the way we must take.

- We have known since beginning this journey that we have many miles to travel to reach our destination and each year's budget is another step toward achieving the very important goals of this Court-ordered Plan.

- The Mayor's proposed FY 2005 budget helps us enormously. It helps us stay on track with the Court-ordered Plan, it helps us avoid potential contempt findings, it helps us to assure the system we are building is on solid footing as we approach and achieve success in the difficult work ahead.

- Without a firm foundation, we cannot take the necessary steps we need to better serve our children and youth. Without a firm foundation, we cannot continue building a recovery-based system for adults. Without a firm foundation, we cannot extend crisis and emergency services to every District citizen who needs these services for themselves and family members.

- Our mental health system is vital to the health and safety of all of us as we have learned over the past three years. We now know how much more vulnerable we are to man-made crises of many different kinds.

- At the same time we struggle to make our community safe for our children. If our children and their children are to succeed in life, we are obligated to take every possible measure to reduce the barriers to learning, to build the capacity of our families to help their children and to assure we have both adequately trained and prepared caregivers when families cannot be there for their children.

- Our mental health system is key to their success. We failed our last generation by denying the importance of children's mental health services and supports, of prevention and early intervention. We simply cannot deny the next generation and the choice is ours.

**Key Issues in the FY 2005 Budget**

- Without a doubt, the key issue for the FY 2005 DMH budget is the Mayor's request to "rightsize" the Department's budget.

- In March 2001, one month before the new Department of Mental Health was created, Mr. Steve Wood, the Transitional Receiver's Chief Financial Officer, reported to you in the FY 2002 budget hearing that the Commission on Mental Health Services and the first Receiver had historically reported over-inflated revenues for both Medicaid and Medicare.

- Mr. Wood, along with several auditors and myself, had just found information that indicated the Center for Medicare and Medicaid

Services also was investigating record keeping errors in 1997 outpatient Medicare claims. This information – along with the knowledge that the Commission had not settled cost reports dating back to 1989 and the Commission had not prepared for significant changes in reimbursement rules about to be implemented by CMS – led us to three immediate action steps.

- First, we stopped billing for Medicaid and Medicare reimbursable services and entered into a voluntary corrective action plan with CMS while we further explored the possible errors in methods and how to change our business practices to comply with CMS proposed changes.

- Second, we began the long and tedious process of reconciling past open cost reports and completing cost reports not yet finished dating back to 1989.

- Third, we presented in the Court-ordered Plan, in Dixon, and in the new Mental Health Establishment Act to create the Department, broad and specific requirements for a new community service delivery and reimbursement system that would satisfy changing CMS requirements and catapult the outmoded, ineffective outpatient clinics operated through St. Elizabeths Hospital.

- Within one month of my appointment as Director, I briefed the City Administrator and Deputy Mayor on the gravity of this situation from my perspective. On August 10, 2001, I briefed the CFO's senior staff and reported the preliminary findings to the CFO.

- Today, we come to you to present the Mayor's budget for the Department of Mental Health for FY 2005, with the problems we found in FY 2001 behind us.

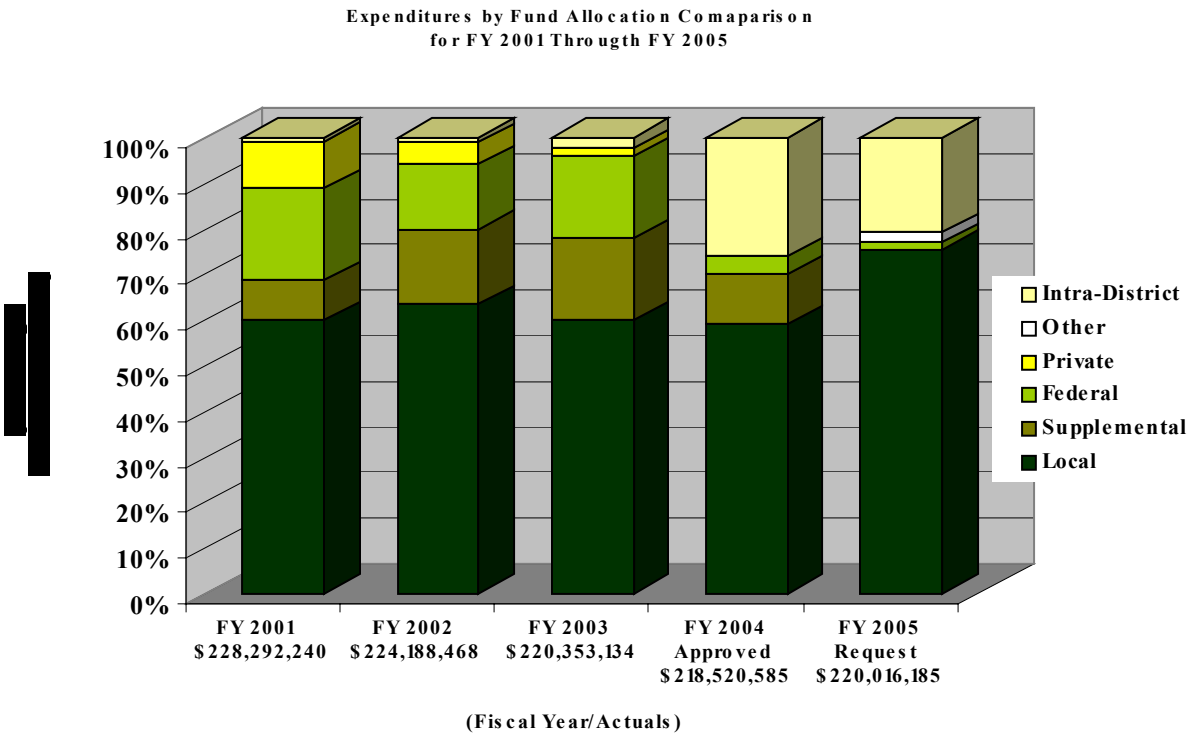
- Today, we come to you to present the Mayor's budget for the Department of Mental Health for FY2005, with a much clearer understanding of our needs and capabilities.

- With the hard work of staff and support of the CFO, the final write-off of uncollectible revenues is behind us. We are caught up with

filing cost reports and most have been fully negotiated. We are well on our way to cleaning up the 1997 records investigation.

- We now know what services we can legitimately bill and what we cannot bill; we have maximized administrative claiming and have created a whole new system for community services billing.

- Therefore, Mayor Williams is requesting we put supplemental budgets and reserve funds behind us and rightsize the agency's budget. That step is to correct the budget by adding $37.2 million in local funds to our base budget for FY 2005, recognizing that approximately the same amount of funding was in reserve and supplemental budgets for the past two fiscal years as illustrated in Exhibit 1 below.



| Fund | | FY 2001 | FY 2002 | FY 2003 | FY 2004 Approved $216,520,585 | FY 2005 Request $220,016,185 | Notes |
|---|---|---|---|---|---|---|---|
| Local | | 136,973,418 | 142,269,855 | 132,197,217 | 128,725,750 | 165,977,859 | |
| | **Subtotal Local:** | **136,973,418** | **142,269,855** | **132,197,217** | **128,725,750** | **165,977,859** | |
| Supplemental | | 19,730,045 | 36,689,771 | 39,129,328 | 23,728,099 | - | Supplemental for FY04 includes $21.7 Mil. of Medicaid Reserve funds and $2.0 Mil. of Pay As You Go Funds. |
| | **Subtotal Supplemental:** | **19,730,045** | **36,689,771** | **39,129,328** | **23,728,099** | - | |
| Federal | Medicaid | 41,002,720 | 26,636,519 | 34,853,293 | - | - | Medicaid for FY04 &FY05 is reallocated to Intra-District funds. |
| | Federal Beneficiary | 4,645,991 | 2,980,238 | 2,642,586 | 3,193,198 | - | FedBen for FY05 has been reallocated to Other Funds. |
| | Medicare | - | - | - | 2,862,611 | - | Medicare for FY05 has been reallocated to Other Funds. |
| | Mental Health Block Grant | 650,581 | 890,303 | 846,113 | 980,293 | 1,130,838 | |
| | Path Grant | | 300,000 | 300,000 | 300,000 | 300,000 | |
| | MHSIP Grant | 109,178 | 23,646 | 28,041 | | | |
| | State Mental Health Data Infrastructure Grant | | 42,168 | 86,202 | 156,902 | | |
| | Multicultural Asserive Community Treatment | 95,092 | 49,859 | - | | | |
| | Dentral Residency Training Program | 2,000 | 60,135 | 76,413 | 106,000 | 216,745 | |
| | Terrorism Related MH Needs Assestment | | 50,000 | | | | |
| | Terrorism Related Diaster Grant | | 272,135 | 189,864 | | | |
| | FEMA Grant | | 761,259 | (761,259) | | | |
| | Emergency Response - Sniper | | | 115,027 | | | |
| | Child Mental Health Initiative (CINGS) | | | 505,756 | 1,459,969 | 2,171,988 | |
| | Emergency Preparedness | | 304,894 | 1,162,398 | | | |
| | **Subtotal Federal:** | **46,505,561** | **32,371,156** | **40,044,435** | **9,058,973** | **3,819,571** | |
| Private | Medicare | 22,250,299 | 9,636,225 | 3,148,475 | - | - | Medicare for FY04 was allocated to Federal Grants. |
| | DC Charter School | 865,087 | 911,317 | - | - | - | |
| | LPC Research Grant | 10,142 | 5,523 | | - | - | |
| | Olsmstead Financial Support Award | | 30,223 | 28,273 | - | - | |
| | Johnson & Johnson Darthmouth | | | 80,000 | 60,000 | - | |
| | **Subtotal Private:** | **23,125,527** | **10,583,287** | **3,256,748** | **60,000** | - | |
| Other | Gift Fund | - | 1,011 | - | - | - | |
| | Federal Beneficiary | | | | - | 2,268,000 | |
| | Medicare | | | | - | 2,540,120 | |
| | **Subtotal Other:** | - | **1,011** | - | - | **4,808,120** | |
| Intra-District | Intra-Districts | 1,957,689 | 2,273,388 | 5,725,407 | 3,792,725 | 2,665,791 | |
| | Medicaid Transfer | - | - | - | 53,155,038 | 42,744,844 | |
| | **Subtotal Intra-District:** | **1,957,689** | **2,273,388** | **5,725,407** | **56,947,763** | **45,410,635** | |
| | | | | | | | |
| **Total Department of Mental Health:** | | **228,292,240** | **224,188,468** | **220,353,134** | **218,520,585** | **220,016,185** | |
| | | | | | | | |
| | Capital Budget | 13,709,759 | 18,902,046 | 13,574,308 | 22,029,703 | 10,900,000 | |
| | Write-off | 61,000,907 | - | 65,890,515 | 0 | - | |
| | | **74,710,666** | **18,902,046** | **79,464,823** | **22,029,703** | **10,900,000** | |
| | | | | | | | |
| **Total:** | | **303,002,906** | **243,090,514** | **299,817,957** | **240,550,288** | **230,916,185** | |
| | | | | | | | |
| | | | | | | | |
| **Notes:** | FY 2004 Budget includes and increase of $21,728,099 Medicaid reserves and the $2.0 million in Pay As You Go fund over the approved $194,792,186. | | | | | | |
| | | | | | | | |
| | | | | | | | |

**(Exhibit 1)**

- It is unrealistic to reduce the agency's budget further and it is unrealistic to increase revenue projections.

**The DMH Budget: An Overview**

- The DMH FY 2005 request of $220,016,185 represents an increase in all funds of $1,475,601 or 1 percent over the amount available to DMH in FY 2004 including Medicaid and other reserves. DMH is reducing its personal services and pharmacy budgets by $802,000 and increasing utilities costs by $2,277,601.

- In local dollars, this represents $37.2 million or a 25.4 percent increase in local funds in the DMH base budget. This increase recognizes that DMH can earn $47.5 million in Medicaid and Medicare and other third party insurers in FY 2005. This is where DMH should have been in earnings instead of the $87 million in projections in the budget we inherited when the new Department was created. These revenue figures are in line with actual earnings for FY 2003 and to date 2004 and adjusted projections for the whole of FY 2004.

- Today, we have the benefit of more straightforward, fiscally and empirically sound analysis to tell us both what is reasonable to earn in revenues and what is both practical and reasonable to expect in the actual delivery of services.

- Our expectations for our mental health system are high. They should be, way too many people have waited way too long for the system to improve. This budget provides the opportunity to put this system on sound financial footing so we can begin to meet those expectations.

- To date, we are meeting the expectations of the federal court, but the court will join the chorus of many on just how long we can take to build this new system of care. Given the vast clean-up job we have taken on since 2001 to put our finances on solid footing, to build infrastructure and to create the building blocks for change,

we cannot turn away now and deny this "rightsizing" request at the Mayor's proposed level.

- Meanwhile, our record on creating efficiencies within our own budget is clear. We have reduced overall spending by 3.7 percent since 2001.

- We did this while making needed changes and including increases for our unionized labor force --on average 3.7 percent -- since FY 2002, while almost tripling our community services caseload from approximately 6,000 in FY 2002 to 16,736 by April 15 of this year, by more than doubling the amount of funds allocated to children's services, and after fixed cost increases of 26.7 percent since FY 2002.

- We are vigilant in reducing costs and we pay close attention to that commitment on a daily basis.

- We fight for new resources outside of the District's local funds budget and we keep increased productivity and Medicaid enrollment at the top of expectations for our system.

**What the "Rightsized" FY 2005 Budget Buys**

The budget rightsizing will buy services and supports vital to the Department's mission:

1. **Continuation of the implementation of the Court-ordered Plan**

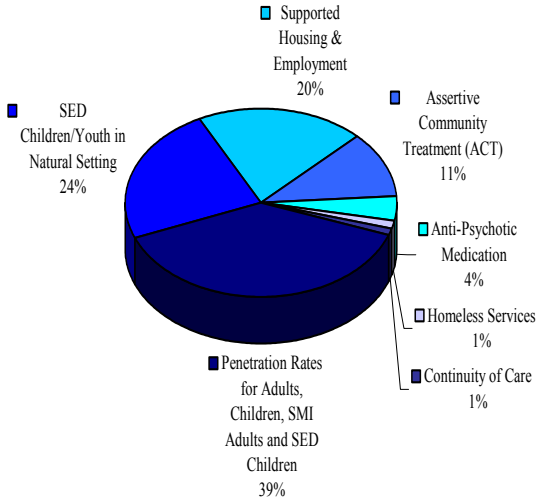
   The DMH is making good progress toward completion of the Plan, is realistic about the time it will take to meet each of the performance targets in the Plan and clear on required progress to eliminate the need for return to receivership or increase Court oversight.

   The inserted chart illustrates the areas covered in the Court-ordered Plan. This chart shows that today the budgeted funds being directed toward meeting the Court-ordered Plan are

$114,757,693 or 52% of our total budget and within that amount how much is being spent in each performance category of the Court-ordered Plan.

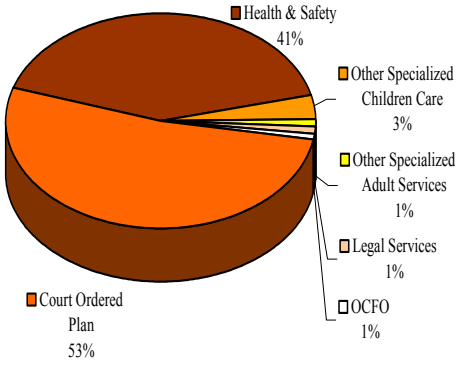
**Court Ordered Plan**

| | |
|---|---|
| Penetration Rates for Adults, Children, SMI Adults and SED Children | 43,943,010 |
| SED Children/Youth in Natural Setting | 27,151,762 |
| Supported Housing & Employment | 23,063,061 |
| Assertive Community Treatment (ACT) | 12,987,076 |
| Anti-Psychotic Medication | 4,869,869 |
| Homeless Services | 1,586,796 |
| Continuity of Care | 1,156,119 |
| | **114,757,693** |




**Department Wide Services**

| | |
|---|---|
| Court Ordered Plan | 114,757,693 |
| Health & Safety | 90,715,365 |
| Other Specialized Children Care | 7,562,542 |
| Other Specialized Adult Services | 2,965,650 |
| Legal Services | 2,048,916 |
| OCFO | 1,966,276 |
| | **220,016,442** |




**(Exhibit 2)**

The largest category is actually in the section titled “penetration”, meaning the costs associated with providing general and certain specialized services under the general heading like in-home community support for adults according to the Court-ordered plan. It is titled “penetration” because it measures the total number of

people we serve in the community on a per capita basis. In total, about one-third of consumers today receive a very specialized service specifically being tracked by the Court so it is listed in a category outside the "penetration" category.

DMH has quantified progress to date in each area, the costs associated with this progress, and percentage increase in each service area we can achieve with the Mayor's proposed budget in FY 2005.

## 2. Develop Services and Maximize Resource Development with Partner Agencies on Behalf of Children and Youth

DMH has specifically focused on expanding services for children and youth over the past two years. This targeting is being done utilizing the principles of the SAMHSA "Systems of Care" approach recognizing the need for an integrated approach to service delivery across systems, specifically including families and caregivers in policy and service delivery and in creating access to effective treatment and supports for youth in their home community and natural settings.

Toward that goal, DMH has initiated a number of intertwined and focused initiatives with support from a significant SAMHSA organizing grant---CINGS. These include:

### *1. Continue emphasizing the certification of child and youth agencies in the Mental Health Rehabilitation Services (MHRS) program.*

Today 11 agencies are certified that provide a significant level of child and youth services. An additional eight providers are in the final phase of certification meaning they could be certified within 30 days and another eight providers are in the middle phase, meaning they could be certified within the 60 days. Today the number of children and youth enrolled is 3386. Our target for enrollment in FY 2005 is 4510.

DMH is specifically targeting the expansion of MHRS services for children and youth in the CFSA and YSA systems. In March alone, DMH enrolled 200 youth for mental health services from the CFSA system. DMH Provider Relations and Child and Family Services staff meet weekly with current and prospective providers to help guide them through certification and to assure they can meet the new demands being placed upon them daily.

DMH is setting aside up to $ 2 million in funds this fiscal year for needed Medicaid match for new agencies and for expansion system wide. As we hoped, new child serving agencies are coming forward thus utilizing the new match at a greater rate than adult agencies. We have made adjustments for that match again in FY 2005 through continued reduction in the reliance on federal dollars in the community contracts budget.

***2. DMH, working with CFSA, will expand resources to children and youth in the foster care system through targeted technical assistance and expansion of services in five critical areas.***

DMH along with CFSA received a specific federal allocation to expand services for youth in the foster care system for FY 2004. As you undoubtedly heard during the CFSA hearing, we are requesting these funds be extended into FY 2005 given the fact that Congress did not approve the portion of their budget that made it possible for the District to load these funds into agency budgets until March 17, 2004, thus giving us less than six months to implement a broad ranging set of services.

Specifically, DMH was appropriated $3.9 million for two purposes. The first purpose is to increase several types of evaluations and to assure assessments can be completed in a more timely manner when requested by CFSA and the Family Court. DMH has allocated $1.3 million for this purpose. Today we have already issued 3 contracts to expand the number of clinicians to provide these services and will continue with this expansion until we can reach a threshold that will enable us to complete and submit most evaluations with 20 days of a request.

Second, DMH was provided $ 2.6 million to assure services can be delivered for foster care children and youth and their families in a more-timely and more effective, productive manner than historically done.

DMH is extending technical assistance to ten providers either under contract to DMH for the provision of MHRS services tailored to meet the needs of troubled youth and their families. This technical assistance began on Tuesday of this week and the first round of technical assistance will be completed by the middle of May.

DMH and CFSA are issuing five solicitations for new and expanded services in the following categories: Mobile Crisis, Intensive In-Home Services, Multi-Systematic Therapy (MST), Intensive Community Support and Specialized Therapies (primarily cognitive therapy, specialized therapy for trauma victims and specialized family therapies). For each of these solicitations, selected providers will be required to enter into rigorous training and technical assistance programs and each provider if not already certified must meet DMH MHRS certification requirements within six months of their selection. This requirement is fundamental to the sustainability of this program.

DMH is working closely with CFSA, jointly managing the program, co-locating staff, integrating support functions, streamlining referral processes and jointly issuing the aforementioned solicitations. DMH is also working with community partners, the Family Court and the Foster Parent Advocacy Center.

***3. DMH is providing additional support to youth in the juvenile system by re-directing current funds to those youth.***

DMH is providing support to divert youth from the juvenile justice system and to increase aftercare services for youth committed to YSA. DMH is providing the diversion support through Alternative Pathways and specifically, Youth Empowerment Services (YES). With the support of MPD, DCPS, Time Dollar Institute and the Institute for Behavioral Change, YES diverts youth at the Juvenile Processing Center and also attempts to link youth who have very

problematic truancy records at four DCPS identified schools including Ballou High School. In FY 2003, DMH was awarded $1.6 million in funds to support this program start-up by the Juvenile Justice Advisory Committee, but continuation funds were not forthcoming. After a short break in service, DMH re-directed funds within its own budget to continue the program. While the funds have yet to be identified to continue this valuable program in FY 2005, DMH is committed to working with its partners to continue the program and maintain a high level of support for diverting youth from the formal juvenile justice system.

DMH is collaborating with YSA to strengthen the aftercare services for youth committed to YSA. Again no new funds have been identified for the FY 2005 but DMH committed to continuing this program. With the urging again of DHS, MPD, PDS, Court Social Services, DCPS, the Charter Schools and other stakeholders, DMH is proposing to establish two new MST teams in FY 2005. Using a MST certified provider, DMH projects two new teams could serve between 96-120 youth with severe behavioral problems, a history of violence and poor school attendance and achieve an 80% success rate. DMH is committed to assuring the selected provider maintain fidelity to achieve these astounding results. This would require approximately $ 650,000 not including start-up costs. After six months, Medicaid can reimburse up to 70% of the total funding.

DMH is also committed to assuring YSA contract providers become MHRS certified just as already begun with CFSA providers this fiscal year. DMH is placing a Continuity of Care Coordinator at Oak Hill to assist with this process and to assure all youth get the necessary referrals to wrap around and other intensive services through MHRS providers prior to and upon release from Oak Hill. DMH also hopes to secure accelerated releases where possible with the addition of needed support for youth who could be better served outside of Oak Hill. Simultaneously, DMH is committed to supporting YSA at the new detention center site.

***4. DMH is continuing to expand its School Based Mental Health Program.***

DMH has experienced tremendous success and support with our School Based Mental Health Program. DMH plans to move into an additional five schools in FY 2005. With the support of DCPS, DMH hopes to secure additional federal support for this expansion. This fiscal year DMH has not expanded the program. The program had grown quite rapidly and needed to be solidified in FY 2004 after moving into almost twenty schools in eighteen months.

***6. DMH will take on full management responsibilities for youth in Residential Treatment Center (RTC) Programs effective October 1, 2004.***

The last major piece to go into place in FY 2005 is DMH assuming responsibility for contracting for all RTC services for youth with mental health and related problems. Today approximately 500 youth are placed in RTCs by CFSA, YSA, DMH, DCPS and the MAA funded managed care contractors. Of that number, close to a third are placed there with local funds only, meaning that Medicaid is not covering any of the cost of their placements. Beginning October 1, 2004, matching and other local funds from other agencies will be transferred through intra District arrangements to DMH.

DMH will certify all RTCs, manage all contracts for placements from YSA, CFSA, DCPS and DMH, pay the full match and take responsibility for continuity of care with support from partner agencies that hold legal responsibilities for each child. Over time savings will accrue from this action that can be used to help support the development of child services in the District. While DMH assumes significant risk with this initiative, it holds tremendous promise and can solidify the expansion and sustainability of all child initiatives.

## Assuring We Can Meet Health and Safety Requirements

### *1. Staffing at Saint Elizabeths*

Staffing at Saint Elizabeths was reduced by 117 in FY 2003. The hard work of combining staff functions has been completed and efficiencies found and implemented. With an aging plant and census reduction slowed by the general increase in demand for services across the District, DMH cannot reduce the Saint Elizabeths budget further.

We also are working closely now with the DC Hospital Association and other acute care hospitals to help alleviate overcrowding and reduce the demand for acute care beds across the city through alternatives to hospitalization.

### *2. Staffing for the Public Core Service Agency*

Likewise, at the Public Core Service Agency we have reduced staffing by 26 since FY 2002. The Public Core Service Agency provides a myriad of services not provided by other Core Service Agencies, including but not limited to staffing Oak Hill; operating CPEP, the District-wide Comprehensive Psychiatric Emergency Program; providing staffing to group homes; providing crisis outreach services including the Sobering Center; and operating a small pharmacy and delivering psycho-education programs for DCPS.

### *3. ACCESS HelpLine/ Care Coordination*

The ACCESS/Care Coordination Program continues to provide responsive services, 24/7. Last week the ACCESS Call Center took 836 calls, an average number, listening to people, enrolling individuals to services and linking children, caregivers and adults to needed emergency, outreach, acute care and follow-up services. The trained Care Coordinators often stay involved in case situations over several days or even several weeks assuring individuals get connected to services they need. As the DMH network of services expands so does the Care Coordination function. Today two staff are located at the Children's Hospital and shortly two staff will be co-located at CFSA. As we plan for FY 2005, it is possible staff will also

be co-located at Oak Hill, at acute care hospitals and emergency rooms. This service is vital to the community and much in demand.

### *4. Auditing and Monitoring*

We have five very important objectives to achieve in our auditing and monitoring of the new service delivery system in the community and St. Elizabeths Hospital:

1. First and foremost, not repeating mistakes of the past with incomplete record keeping and lack of substantiated service delivery by conducting pre-audits before any provider is allowed to bill and before claims are submitted for St. Elizabeths and the Public Core Service Agency plus retrospective audits of record completeness.

2. Assuring fidelity to the service descriptions and service models being implemented to meet both Court-ordered Plan and CMS requirements.

3. Investigating major incidents and monitor for quality services.

4. Assuring we are not overestimating eligible days of service for reimbursement purposes at St. Elizabeths.

5. Auditing the fiscal viability of each community provider to assure the agency can meet its financial and service requirements to the consumers it serves.

Today, with a combination of staff at the PCSA, St. Elizabeths and in the Mental Health Authority, under the guidance of the DMH Chief Compliance and Regulatory Counsel, the Deputy Director for Accountability, the Risk Manager and Internal Auditor, over 30 staff in either part time or full time roles contribute to these functions and are helping DMH achieve these five very important objectives.

### *5. Safe Places for People to Live and Work*

The Mayor is steadfast in his commitment that consumers have a safe place to live and that our staff work in a safe, healthy environment. Toward that end, the DMH capital budget for FY 2005 includes $5.5 million for housing expansion and $ 4.0 million for rehabilitation of the CPEP facility along with $ 1.4 million for the Saint Elizabeths information technology improvement.

## Delivering on Revenue Commitments

DMH has developed a solid plan to meet its revenue targets while at the same time assuring the services being reimbursed are critical to the mission of the agency, focused on the most critical, medically necessary services while reinforcing the core principles of recovery and resiliency. The plan has five major components:

### *1. Medicaid Revenue*

The Department receives Medicaid reimbursement from two sources – Inpatient Services – Saint Elizabeths Hospital; and Outpatient Services Community-based MHRS certified providers including Medicaid Administrative Claiming.

Inpatient Services – Saint Elizabeths Hospital

Saint Elizabeths Hospital provides certain Medicaid reimbursable services to Medicaid eligible inpatient clients. The hospital has begun to recover Medicaid revenue as of October ’03. A diligent process to scrub billing data before submission for payment accomplished this objective. There is also more aggressive follow-up to resolve issues, which included denials, on a current basis. Currently, the process to bill for inpatient services is done manually. In FY04, the hospital will procure a new automated system for both clinical and billing purposes.

Outpatient Services - Community-based MHRS Certified Providers

As part of the Dixon Court-ordered Plan, the Department certified community-based providers to render Medicaid reimbursable

outpatient mental health services. DMH's plan to meet its Medicaid revenue targets through community-based providers has six components – (a) Continued Technical Assistance and Training; (b) Auditing and Monitoring; (c) Recruitment and Matriculation of New MHRS Certified Providers; (d) Conversion of Grant-based Contracts to Fee-for-service Contracts; (e) Automation of DCPCSA Billing and (f) Medicaid Administrative Claiming.

(a) Continued Technical Assistance and Training

During FY 2004, DMH entered the third phase of its technical assistance and training program, which called for individualized provider technical assistance (TA) and targeted group training. For the individualized provider TA, DMH has the assistance of a nationally known consulting firm specializing in assisting providers in successfully transitioning in to a fee-for-service environment. Last fiscal year, this technical assistance proved to be successful for DMH's providers in that it was very instrumental in stabilizing two provider's financial conditions. DMH Provider Relations staff worked along side and were trained by the consultants to provide the same kind of individualized TA.

The DMH Training Institute has revised some of its training modules to address the new challenges providers are confronting as they enter their second year of providing services under the MHRS fee-for-service model.

(b) Auditing and Monitoring

As mentioned above, before DMH submits claims to Medicaid, DMH conducts an audit of the provider's billing process. DMH follows the billing process from the front desk to the final submission of a claim. From this audit process, DMH can identify any problems in the provider's internal process, which would make billing MAA problematic. Also, the audit process identifies areas where providers could use training. This assures that the revenue is collectible.

(c) Recruitment and Matriculation of New MHRS Certified Providers

DMH is aggressively recruiting providers of children and youth services to become MHRS-certified. Besides supporting DMH in building a children and youth mental health service system capacity, most children and youth providers are eligible to become Medicaid-certified providers, which broadens the DMH Medicaid-provider base. These providers can serve children and youth that are new to the system thereby increasing DMH capacity to billing Medicaid.

(d) Conversion of Grant-based Contracts to Fee-for-service Contracts

DMH is systematically converting grant-based local fund supported contracts to Medicaid fee-for-service contracts. DMH has identified certain grant-based services that once unbundled from other services can become Medicaid reimbursable services. These services would increase the DMH Medicaid reimbursable service base.

(e) Automation of DCPCSA Billing

During FY 2003, the implementation of the Anasazi practice management information system began at the Public Core Service Agency. Once fully implemented (Dec 05) this application will streamline billings and receivables management as well as automate many of the agency's current manual processes including, client registration, and scheduling and clinical documentation.

(f) Medicaid Administrative Claiming

In April 2002, the Department submitted and CMS approved the Department's cost allocation plan for Medicaid administrative claiming. Currently, we are projecting $4M in Medicaid Administration cost for FY 2005.

### *2. Medicare Revenue and Federal Beneficiaries*

Medicare

Key to our ability to receive reimbursement from Medicare has been the continued improvement in the timeliness of the submission of cost reports. Medicare had resumed reimbursements to the hospital. In doing so, they recognized our ability to submit more comprehensive documentation for patient services. The payments to the hospital have been temporarily suspended subsequent to the submission of the '03 cost report. This is not bad news, it shows that there has been significant dialogue with Medicare and improvement in the hospital's ability to solve documentation problems.

Federal Beneficiaries

The U.S. Marshall has resumed payments to St. Elizabeths. 98% of all payment requisitions were reimbursed for FY03 as of March of 2004. They have also submitted payments through January of 2004 and promised to remain current.

### *3. Timely Cost Report Completion*

Today I am pleased to announce that after an almost 20-year history of problems with filing and negotiating cost reports we are current and we will submit our FY 2003 Cost Reports prior to our April 30th target date next Friday.

### *4. Infrastructure Development*

DMH successfully installed and developed a business model predicated on the success of a payer system for billing and reporting that can also generate information for management and auditing. The specific application that drives this system is *Ecura.*

DMH predicted it would take two years to successfully implement its business model using this application. We have just crossed that two-year threshold and today we are very close to meeting our targets for this system. Our last hurdle is the successful

implementation of HIPAA-required claims submissions accompanied by detailed level of information to providers. While not our responsibility, we also are hopeful that each provider can successfully bill with these new HIPAA requirements. Today that is not yet a reality.

DMH also is closely monitoring our ability to pay claims within 30 days of receiving clean claims. This was a challenge earlier in the year when the DMH budget was not fully loaded and accessible for DMH to pay providers. With the support of you, Chairwoman Allen, and the City Administrator we were able to bring this problem of loading the budget to resolution and we are now able to meet our payment targets. In FY 2003 we paid 87 percent of claims within 30 days and 94 percent within 60 days when we backed out three providers with high levels of claims adjudication difficulties. We will meet and hopefully exceed those targets in FY 2004. The system can continue to be streamlined but we have learned a great deal and have quickly made changes.

**5. Auditing and Monitoring**

As referenced above, DMH has taken on an enormous task to audit and monitor providers' operations. These tasks have a dual purpose. In addition to providing information to assure the health and safety of consumers, completing these tasks in a timely and strategic manner allows DMH to meet its obligations to produce revenues and reporting and other requirements.

**Why is this Request so Urgent?**

As stated in my introduction, in FY 2001, the Transitional Receiver, in the *Dixon v Williams* case, and the Director of the new Department of Mental Health uncovered significant billing and revenue problems, while examining the state of and determining the future direction for the mental health system. As a result of the discovery of the billing and revenue problems, the Transitional Receiver and the Director suspended Medicaid and Medicare billings. The billing and revenue problems were found in the Commission on Mental Health Services (CMHS), the former District mental health agency.

Through the examination of work papers of the Commission on Mental Health Services administrators and the beginning operations of the new Department of Mental Health, it became very clear that:

- The revenue projections for FY 2001 and prior years by the former Commission on Mental Health Services administrators were unrealistic.

- For FY 2002 through FY 2004, supplemental appropriations were needed to balance DMH budget.

- By FY 2004, a funding level of $220.0 million would be necessary to fund the level of services to provide for the appropriate health and safety for the District including the services contemplated in the Dixon Court-ordered Plan.

If the DMH does not receive this request, it would be forced to take actions in several areas of work force and service delivery:

1. Cut Services - Without the enhancement, DMH would cut services. More specifically, DMH would:

   - Limit DC Public Core Service Agency services to free care clients:

   *Case Mix*

   At this juncture, it has been determined that 40 percent to 50 percent of the PCSA's caseload consists of persons who do not qualify for benefits because of their documentation status or persons who are above the Medicaid financial eligibility limit but without insurance. The PCSA caseload more closely reflects the Alliance caseload, not a Medicaid reimbursable base. If DMH did not receive this request, DMH would be forced to limit mental health supports and services to this population. The effect would be that they would go without treatment for their mental illness.

Other services would be limited:

*Pharmacy* – The PCSA operates a pharmacy at three locations. The pharmacy provides services to individuals without insurance coverage.

*Emergency Services* – The PCSA manages and operates the District-wide mental health emergency unit, which is not currently reimbursable from any third party payer. These PCSA provided services are mandated by the District of Columbia rules and laws, by the Court ordered Plan as well as necessary for health and safely for the District.

*Services at Oak Hill* – The PCSA provides mental health services at Oak Hill Youth Center in accordance with *Jerry M.* requirements.

*Other non-reimbursable services* – The PCSA provides other services such as staff for group homes, psycho-educational services for youth with special needs and services for persons who are homeless.

- Slow-down the Implementation of the Mental Health Rehabilitation Services Model

  By slowing down, we mean, reducing benefits in the system by reducing the number of counseling hours or day treatment days for consumers. We already do this when we can no longer confirm the consumer meets medical necessity criteria, but if the budget were not approved we would be faced with contempt of Court.

- Suspend the Expansion of Children and Youth Services

  Under the District mandate, DMH must expand mental health services provided to children and youth and bring children and youth back from out-of-state residential facilities. The service expansion will include traditional Medicaid reimbursable services and non-traditional non-Medicaid reimbursable

services. The non-traditional services will be supported by local funds.

2. Cut staff at the Mental Health Authority and St. Elizabeths Hospital.

- At the Authority, the three areas with the most staff are Accountability, the staff who inspect residential facilities, conduct quality review audits and certify providers; and the information systems staff who are presently installing two information systems and the Access HelpLine the 24-hour Care Coordination Center. Both of these areas are required in the Court-ordered Plan. Almost all other areas of the Authority are required functions with three or fewer staff in the specific area or in the case of children's services, operating with federally funded staff.

- At St. Elizabeths any cuts would affect patient care as the hospital staff was shrunk in last year's reduction-in-force in all areas outside of critical patient care and maintenance, which at this point is keeping an old and crumbling campus barely functioning.

**Summary**

We have made measurable progress toward implementing the Court-ordered Plan and assuring the delivery of quality mental health services to all District residents. To create sound financial foundation to support our work, we need to "rightsize" our budget by putting $37.2 million into our local funds appropriation.

Thank you, Chairwoman Allen and members of the Council for this opportunity to testify. My staff and I are prepared to answer your questions.